

Michigan WIC Special Formula/Food Request Form

Client: _____ DOB: _____ Parent/Guardian: _____

1. QUALIFYING MEDICAL CONDITION(S):

- ☐ Premature birth < 37 weeks gestation
- ☐ Failure to thrive
- ☐ Severe food allergies (Specify) _____
- ☐ Immune system disorder (Specify) _____
- ☐ Metabolic disorder/inborn errors of metabolism (Specify) _____
- ☐ Medical condition that impairs nutrition status (Specify) _____
- ☐ Gastrointestinal disorder/malabsorption syndromes (Specify) _____

Conditions such as rash, non-specific intolerance, underweight, fussiness, colic, spitting-up, vomiting, gas and constipation will **NOT** be considered indications for a special formula. **Please specify the underlying medical condition.**

2. FORMULA: _____ AMOUNT* Needed per Day _____

*If not specified, up to the WIC maximum allowable may be provided, Maximum allowable may not meet patient's full need.

A list of Michigan Authorized Formulas is available at: www.michigan.gov/WIC Click on Link: Medical Providers

3. SUPPLEMENTAL WIC FOODS: (CHECK ONE; MUST BE COMPLETED FOR ALL FORMULA REQUESTS)

☐ **All** (Issue all allowed age appropriate WIC Foods starting at six months)

☐ **Restriction (Check foods to be OMITTED):**

Infant (6-12 months)

- ☐ All (Issue formula only)
- ☐ Infant cereal
- ☐ Infant fruits/vegetables

Child (1- 5 Years) and Woman

- ☐ All (Issue formula only)
- ☐ Milk
- ☐ Cheese
- ☐ Eggs
- ☐ Legumes
- ☐ Peanut butter
- ☐ Breakfast cereal
- ☐ Bread, rice, tortilla, oatmeal
- ☐ Fresh fruits/vegetables
- ☐ 100% fruit/vegetable juice
- ☐ Canned fish (women only)

Special Instructions/Comments:

4. MILK SUBSTITUTIONS (Optional): MEDICAL REASON FOR MILKFAT CHANGE _____

☐ **2% milk** (in place of: ≤1% milkfat, woman/child ≥ 2 yrs; or whole milk, child 12-23 mo.). Honored only if medically indicated.

☐ **Whole milk** (in place of ≤1% milkfat, woman/child ≥ 2 yrs): Honored only if medically indicated formula prescribed above.

☐ **Soy Beverage in place of milk for child:**

☐ Milk allergy ☐ Lactose intolerance ☐ Vegetarian/Vegan diet ☐ Cultural practice ☐ Other: _____

5. DURATION:

☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months (*maximum approval*)

Medical Provider Name:

WIC Use Only

Client # (Optional)

Address:

Approved Through (Optional):

Phone:

Fax:

Reason (If Denied):

Signature:

Date:

Signature (If Denied):

Date:

WIC CLINIC: _____ Phone: _____ Fax: _____